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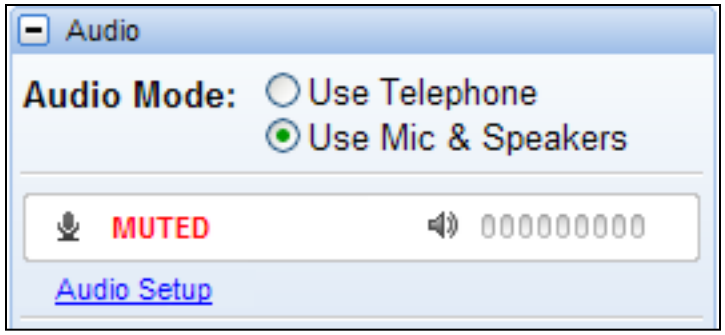

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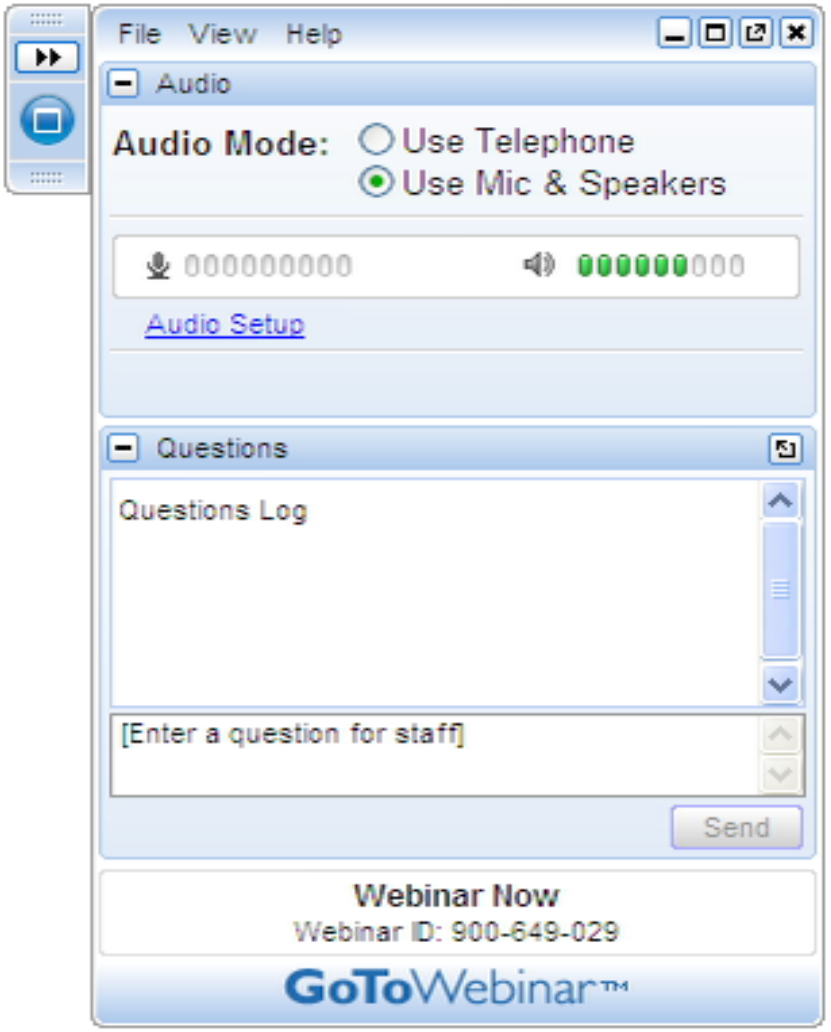
Webinar Tips

- Attendee Control Panel
- Asking Questions



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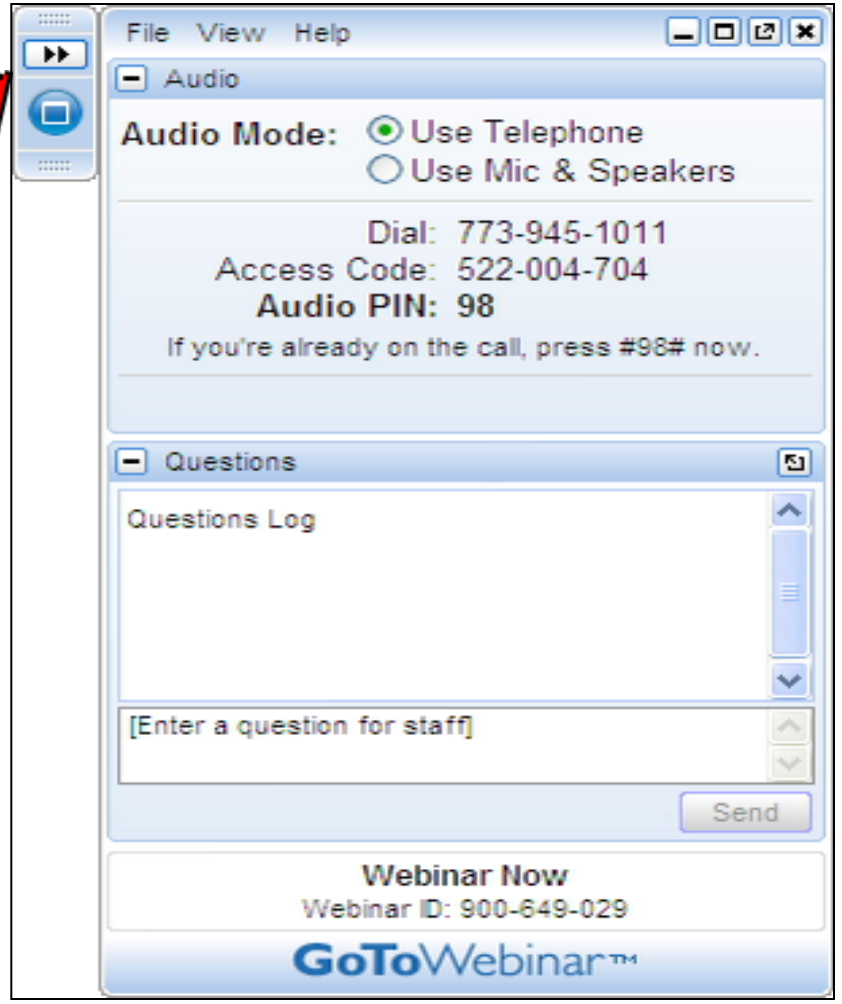
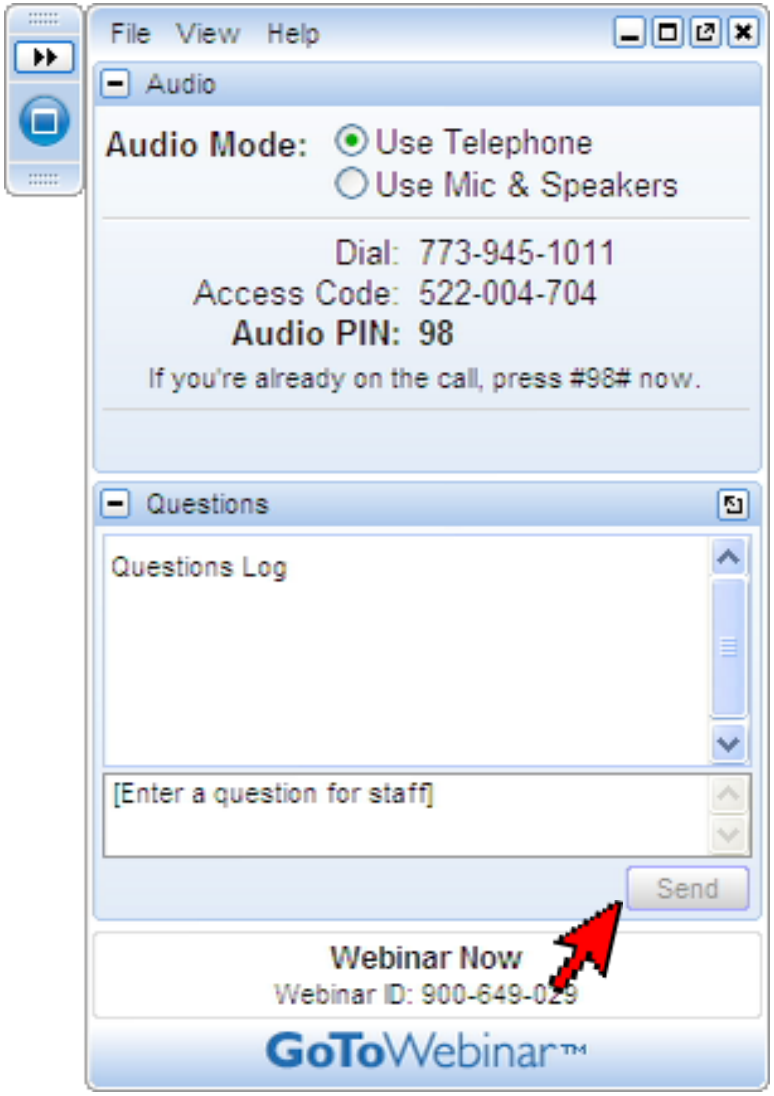


Asking Questions

- You may ask questions any time during the Webinar
  - Click the Questions option in the Webinar toolbar
  - Type in question
  - Click Send
- Selected questions will be answered during the Webinar – time permitting
- Questions will be reviewed for inclusion in future communications from the Department



OPERATIONAL WEBINAR SERIES:

HOW TO BILL MEDICARE CROSSOVERS IN PROVIDERONE

- **Copy of this presentation located at http://www.dshs.wa.gov/pdf/provider/Webinar/MedicareCrossover.pdf**

Learning Objectives

- **After this webinar, you will be able to:**
  - **Verify if a Client has Medicare and determine the type of coverage they have**
  - **Bill Medicare crossovers on professional and institutional claim formats electronically**
  - **Better understand the Payment Methodology for Medicare parts A, B, and C**
  - **Learn tips on billing crossovers successfully**

ProviderOne System Updates

- Recent Discoveries Which Have Been Addressed
  - "Resubmit" feature in DDE
    - Medicare information was incorrectly posting in the commercial insurance fields
  - Rentals
    - Start date that crossed over from Medicare resulted in the application of a per diem rate to 30 day rental
  - Pricing
    - Some Medicare Only covered codes had to be manually priced
- Medicare Crossover Processing
- Electronic Claims processing much faster
  - Strongly encourage move from paper to electronic
  - Staff working to reduce inventory of paper claims

Common Terminology

- **Coinsurance**
  - An amount a Medicare client may be required to pay as their share of the cost for services after they pay any deductibles
    - Under Part A, coinsurance is a per day dollar amount.
    - Under Part B, coinsurance is generally 20% of allowed charges.
- **Deductible**
  - The amount for which a beneficiary is responsible before Medicare starts paying, or the initial, specific dollar amount for which the applicant or client is responsible.

Common Terminology (cont.)

- **Explanation of Medicare Benefits (EOMB)**
  - A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.
- **Capitated Copayment**
  - A predetermined set dollar amount received by a medical provider for services rendered paid by an insurance company regardless of utilization of those services
- **Non-Capitated Copayment**
  - A copayment received by a medical provider who also bills Fee For Service per visitation of the client

Overview - Medicare Crossovers

- Medicare Crossover Claims are claims for the client's Medicare cost sharing liability (deductible, coinsurance, or copay).
- There are 4 types of Medicare coverage:
  - Medicare Part A
    - Covers inpatient hospital services
  - Medicare Part B
    - Covers professional, outpatient hospital, and vendor services
  - Medicare Part C
    - A Managed Care version of Medicare, also called a Medicare Advantage Plan, offered through private insurance companies
  - Medicare Part D
    - Covers prescription drugs

Overview – Medicare Crossovers

- **Must be contracted with both Medicare and Medicaid to bill DSHS for secondary payment**
- **You must bill Medicare as the primary payer if Medicare covers the service provided.**
- **When is a claim a Medicare Crossover claim?**
  - **If you bill us secondary to Medicare and Medicare pays or applies to the deductible, it is a crossover**
- **When is a claim NOT a crossover claim?**
  - **Claims denied by Medicare are not crossover claims.**
  - **If you bill us secondary to Medicare, and Medicare does not pay we still require the Medicare EOB to demonstrate non-payment.**

Overview – Medicare Crossovers

- **Sometimes Medicare does not forward claims automatically to the Department**
  - **Can submit in Direct Data Entry without the EOMB.**
- **Medicare may not forward your crossover claim directly to the Department because:**
  - **Patient is new Medicare/Medicaid enrollee and Medicare does not yet list them as having Medicaid.**
  - **You have billed Medicare with an NPI number that has not been reported to the Department.**
  - **Electronic File Issues**

Overview - Medicare Crossovers

- You will know if Medicare has not forwarded your crossover claim to the Department if:
  - It does not show up on your Medical Assistance Remittance Advice; or
  - The message “This information is being sent to either a private insurer or Medicaid” or “MA07” does not show up on your EOMB.
- Things to consider
  - Why didn’t your claim cross over from Medicare to begin with?
  - Why are you having to submit your crossovers to DSHS?

Overview - Medicare Crossovers

- **If Medicare denies a Medical Assistance-covered service that requires Prior Authorization, the service still requires authorization**
  - **You may request it after the service is provided.**
  - **The Department waives the "prior" requirement in this circumstance.**

Medicare Eligibility

- **The client must have proper eligibility in order for secondary payment after Medicare can be considered.**
  - **QMB – Medicare Only (Qualified Medicare Beneficiary)**
    - **This program pays for Medicare premiums and pays for deductibles, coinsurance, and copayments according to Medicaid rules.**
    - **If Medicare covers the service, the Department will consider secondary payment.**
  - **CNP-QMB (Categorically Needy Program – Qualified Medicare Beneficiary)**
    - **Client has full Medicaid as well as QMB benefits.**

Medicare Eligibility

- **Programs that DSHS would not consider for secondary payment after Medicare**
  - **SLMB (Special Low Income Medicare Beneficiary)**
    - **This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.**
  - **QI-1 (Qualified Individual 1)**
    - **This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.**
  - **QDWI (Qualified Disabled Working Individual) –**
    - **This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.**

Medicare Eligibility

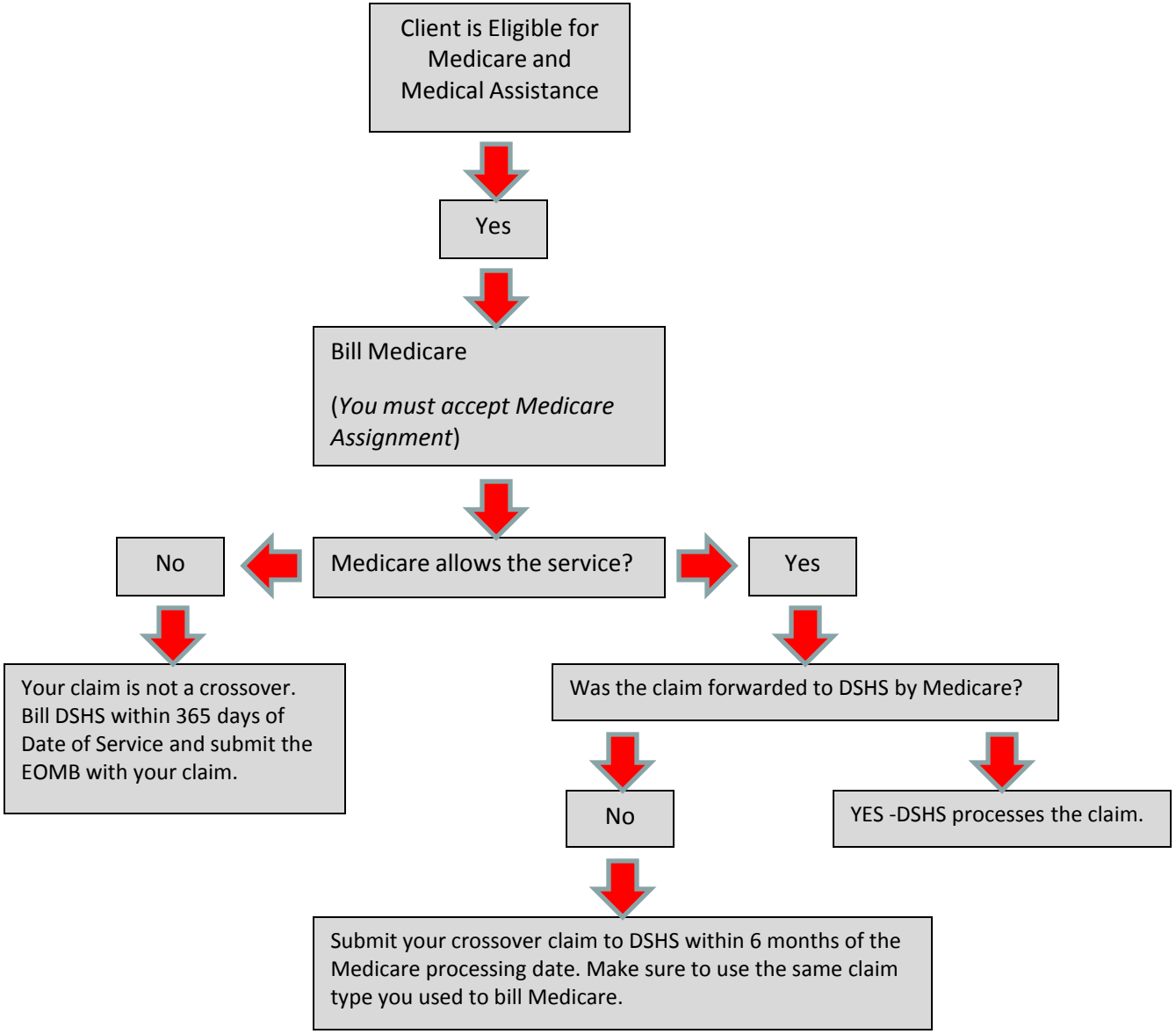
- Determine Medicare eligibility using

Medicare Eligibility Information

Service Type Code	Insurance Type Code	Eligibility Start Date	Eligibility End Date
30: Health Benefit Plan Coverage	MA: Medicare Part A	01/01/2004	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	01/01/2004	12/31/2999

  - The Medicare HIC number under the "Client Demographic Section"
  - MEV Vendors
  - Magnetic Swipe Card Readers
  - IVR system to obtain Medicare information
    - Page 42 - ProviderOne Billing & Resource Guide: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html
  - Future Enhancement: Medicare Part C

The Medicare Crossover Process



Crossover Payment Methodology

- **Professional Services (CMS-1500, 837P)**
  - **The Department compares the Medical Assistance allowed amount to Medicare's allowed amount for the service, selects the lesser amount of the two, then deducts Medicare's payment from the amount selected.**

    Payment = [lesser of Medicaid or Medicare Allowed] – Medicare Paid
  - **For the Qualified Medicare Beneficiary (QMB) - MEDICARE ONLY Benefit Service Package eligible client, if there is no Medical Assistance allowed amount for the service; Medical Assistance uses Medicare's allowed amount for the service.**

    Payment = Medicare Allowed – Medicare Paid

Crossover Payment Methodology

- **Professional Services (CMS-1500, 837P) cont.**
  - **If there is a balance due, the Department pays the client's cost sharing liability (deductible, coinsurance, or co-pay) up to the lesser of the allowed amounts.**
  - **If there is no balance due, the Department does not make any crossover claim payment.**

Crossover Payment Methodology

- **Professional Services (CMS-1500, 837P) cont.**
  - **The Department cannot make direct payments to clients to cover the client's cost sharing liability (deductible, coinsurance, or co-pay) amount of Part B Medicare claim. The Department can pay these costs to the provider on behalf of the client when:**
    - **The provider accepts assignment; and**
    - **The total combined payment to the provider from Medicare and Medical Assistance does not exceed Medicare or Medical Assistance's allowed amount for the service, whichever is less.**

Crossover Payment Methodology

- **Institutional Services (UB-04, 837I)**
  - **For institutional claims, Medical Assistance uses the total claim allowed amount to determine payment. Any payment made is applied toward the client's cost sharing liability (deductible, coinsurance, or co-pay).**
  - **In general the pricing methodology is:**

Payment = [Medicaid Allowed – Medicare Paid] or [Sum of Coinsurance + Deductible] (which ever is less)

For full details, see the Inpatient Billing Instructions, page H.2 at http://hrsa.dshs.wa.gov/download/BI.html#H

- **RHC and FQHC providers**

Crossover Payment Methodology

- **Institutional Services (UB-04, 837I) cont.**
  - **The Department would adjust any payment amounts if the client has a Commercial Medicare supplement policy (TPL) and that supplement payer makes a payment after Medicare. In that case, the formula would be:**
    - **Payment = {[Medicaid Allowed – Medicare Paid] or [Sum of Coinsurance + Deductible] (which ever is less)} - TPL**

MEDICARE BILLING PART B

Medicare Billing – Part B

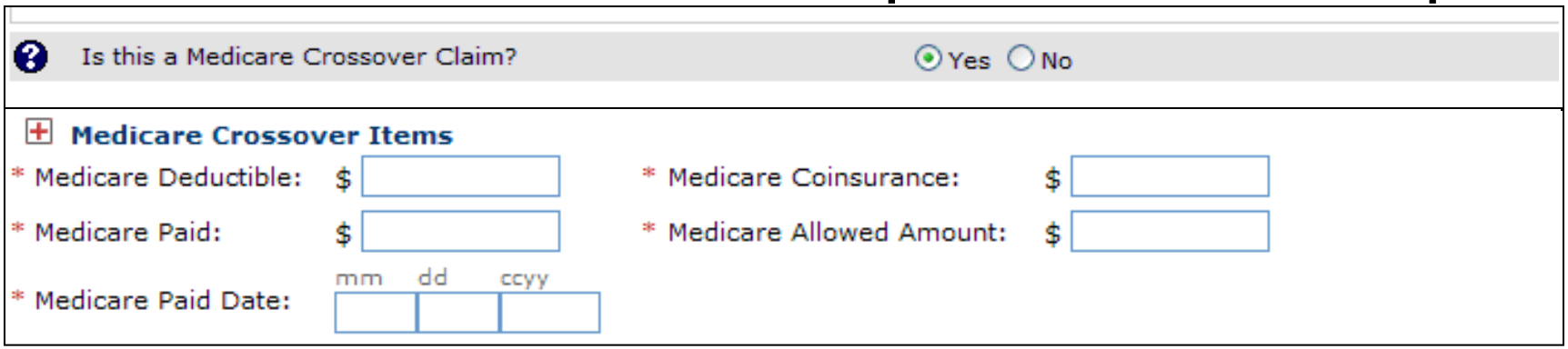
- **CMS-1500, 837P**
  - **If Medicare has paid all lines on your claim ,submit the crossover claim to the Department.**
  - **If Medicare has allowed and denied service lines on your claim, do not submit paid lines with denied lines to the Department on the same claim, as this could cause a delay in payment.**
    - **You will need to submit 2 claims to the Department;**
      - **one crossover claim for services Medicare paid and;**
      - **one professional claim for services Medicare denied.**

Medicare Billing – Part B

- **CMS-1500, 837P cont.**
  - **If Medicare denies a service that requires PRIOR authorization (PA) by the Department, the Department waives the PRIOR requirement**
    - **DSHS still requires authorization for the service based on medical necessity ,which may be requested after the service is provided.**
- **Bill the Department using the same claim format billed to Medicare with the same services and billed amounts. (Direct Data entry and EOMBs)**
- **Medicare is Medicare**
  - **DSHS does not consider Medicare as insurance**

Medicare Billing – Part B

- **When submitting via Direct Data Entry (DDE)**
  - **Click the Radio button "yes" to indicate this claim is a crossover**
  - **Additional service item boxes open to be filled in as required.**



- **The rest of claim information is filled out as normal.**
- **If you bill a crossover using the DDE feature, the Department does not require the EOMB.**

Medicare Billing – Part B

- **HIPAA batch 837P**
  - **HIPAA companion guide http://hrsa.dshs.wa.gov/DSHSHIPAA/attachments/pdf/837CG103009.pdf (beginning on page 41)**
  - **Medicare Information**
    - **Loop 2320 – Other Subscriber Information**
      - **SBR04 – Medicare**
      - **SBR05 – MB**
      - **SBR09 – MB**

Medicare Billing – Part B

- **HIPAA Batch 837P continued**
  - **Medicare Payment Information**
    - **Loop 2320 – Coordination Of Benefits**
      - **AMT01 = D-Medicare Paid Amount**
      - **AMT01 = AAE-Medicare Approved Amount**
      - **AMT01 = B6-Medicare Allowed Amount**
      - **AMT01 = F5-Patient Paid Amount**
    - **Loop 2330B – Claim Adjudication Date**
      - **DTP03 = Medicare Paid Date (CCYYMMDD)**

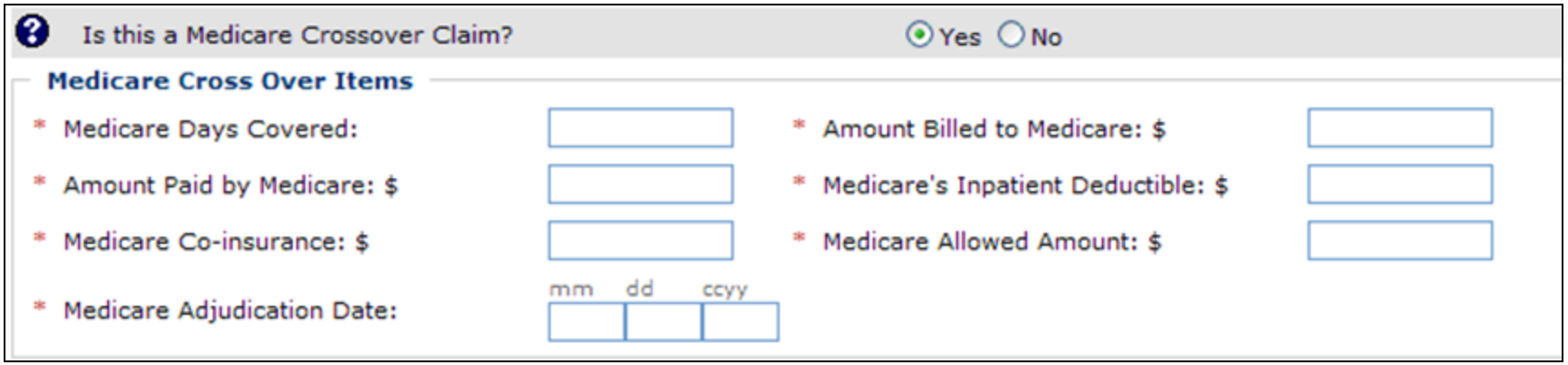
MEDICARE BILLING PART A

Medicare Billing – Part A

- **UB-04, 837I**
  - **If you bill Medicare using the UB-04 claim format, you would bill the Department using the same claim format. Include the same services and billed amounts you sent to Medicare.**
- **You can:**
  - **Submit DDE crossover claims in ProviderOne**
  - **or via electronic batch**
- **RHC note**
  - **One date of service per claim form**

Medicare Billing – Part A

- **When submitting DDE institutional crossover claims in ProviderOne, you will need to fill out additional information:**
  - **Click Radio button "yes" to indicate claim is a crossover**
  - **Additional service items boxes open to be filled in.**



- **The rest of claim is filled out as normal.**

Medicare Billing – Part A

- **HIPAA batch 837I**
  - **HIPAA companion guide http://hrsa.dshs.wa.gov/DSHSHIPAA/attachments/pdf/837CG103009.pdf (beginning on page 81)**
  - **Medicare Information**
    - **Loop 2330B – Other Payer Name**
      - **NM103 - Medicare**

Medicare Billing – Part A

ProviderOne

- **HIPAA Batch 837I continued**
  - **Medicare Payment Information**
    - **Loop 2320 – Claim Level Adjustment**
      - **CAS01 = PR-Patient Responsibility**
      - **CAS02 = 1-Deductible Amount**
      - **CAS02 = 2-CoInsurance**
    - **Loop 2320 – Coordination Of Benefits**
      - **AMT01 = B6-Medicare Allowed Amount**
      - **AMT01 = T3-Medicare Total Submitted Charges**
      - **AMT01 = N1-Medicare Paid Amount**
    - **Loop 2330B – Claim Adjudication Date**
      - **DTP03 = Medicare Paid Date (CCYYMMDD)**

MEDICARE BILLING PART C

Medicare Billing – Part C

- **Some Medicare clients have elected to enroll in a Medicare HMO plan called a Medicare Advantage Plan (Part C)**
  - **Providers are required to bill these Medicare Advantage Plans instead of FFS Medicare.**
  - **The Managed Medicare – Medicare Advantage Plan is the primary payer.**
  - **Follow the billing guidelines established by the Managed Medicare – Medicare Advantage (Part C) Plans prior to billing Medical Assistance**
  - **Medicare Advantage plans are still Medicare**

Medicare Billing – Part C

- After Medicare Advantage plan processes the claim, submit the claim to Medical Assistance.
  - Bill Medical Assistance on the same claim format.
  - Make sure the services and billed amounts match what you billed to the Medicare Advantage plan.
  - No EOMB needed for DDE.
- The Department must receive the Medicare Advantage claim within 6 months of the Medicare Advantage payment date.

Medicare Billing – Part C

- If there is a Capitated Copayment due on claim:
  - Capitated copayments do not require the biller to submit a claim to the Department with an explanation of benefits (EOB);
  - Indicate "Managed Medicare Capitated Copayment" on the billing forms as follows:
    - Electronic billing (DDE) in the "claim notes" section
    - CMS-1500 Claim Form in field 19;
    - UB-04 in form locator 80
  - Bill just the Capitated Copayment

Medicare Billing – Part C

- If there is coinsurance, a deductible, or a Noncapitated Copayment due on a claim:
  - If a balance is due for services provided
  - Indicate "Managed Medicare" on paper billing forms as follows:
    - CMS-1500 Claim Form in field 19;
    - UB-04 in form locator 80
  - No entry of "Managed Medicare" in Claim Notes needed for Direct Data Entry or electronic batch

Medicare Billing – Part C

- **The Department will compare the allowed amount for Medical Assistance and the Managed Medicare – Medicare Advantage Plan and select the lesser of the two.**
  - **Payment is based on the lesser of the allowed amounts minus any prior payment made by the Managed Medicare – Medicare Advantage Plan.**
  - **If Medicare Advantage denies a service on a claim, the Department may or may not make a payment on the service depending on the reason for the Managed Medicare - Medicare Advantage Plan denial.**
  - **If no balance is due, the claim will be denied.**

Medicare Billing – Part C

- **QMB – Medicare Only Clients**
  - **If Medicare Advantage and Medical Assistance cover the service:**
    - **The Department pays only the client's cost sharing liability (deductible, and/or coinsurance, and/or copayment) up to the Medicare Advantage or Medical Assistance allowed amount, whichever is less.**
    - **Payment based on the lesser of the allowed amounts minus any prior payment made by Managed Medicare – Medicare Advantage Plan.**
  - **If only the Medicare Advantage Plan covers the service and Medical Assistance does not:**
    - **Medical Assistance pays only the deductible and/or coinsurance, and/or copayment up to Medicare Advantage Plan's allowed amount.**

Medicare Billing – Part C

- **QMB- Medicare Only Clients (continued)**
  - **If the Medicare Advantage Plan does not cover the service, the Department does not pay for the service.**
  - **Discrepancies, disputes, protests, or justifications for a higher fee or payment for any claim should be directed to your Managed Medicare – Medicare Advantage plan.**
    - **If Managed Medicare - Medicare Advantage adjusts the payment and the claim has previously been paid, you may submit an adjustment request to Medical Assistance.**
    - **Submit a new claim if the original claim was denied.**

Tips on Billing Crossovers

- **There may be a delay or denial in payment if any of the following situations occurs:**
  - **Billing Medicare with an NPI that has not been reported to Medical Assistance.**
    - **The Department will not be able to identify the provider when these claims are forwarded by Medicare to Medical Assistance.**
  - **Billing a paper crossover claim to the Department without a copy of the Medicare EOB attached.**
    - **This will cause your claim to be denied.**
  - **The claim format billed to Medicare does not match the claim format billed to Medical Assistance.**
    - **Your claim will be denied.**

Tips on Billing Crossovers

- There may be a delay or denial in payment if any of the following situations occurs:
  - The coding and dollar amount billed do not match.
  - Failing to indicate the Spenddown amount on your claim.
  - Discrepancies on Medicare Coverage
- Final consideration for billing and taxonomy codes when submitting claims to Medicare
  - Scenario 1: DSHS requires both billing and servicing taxonomy
  - Scenario 2: DSHS only requires billing taxonomy

Tips on Billing Crossovers

- **Scenario 1 - DSHS requires both the billing taxonomy and rendering taxonomy**
  - **Bill to DSHS as Follows**
    - **Billing NPI 1234567890**
    - **Billing Taxonomy 193200000X**
    - **Rendering NPI 1122334455**
    - **Rendering Taxonomy 207E00000X**
- **Creating a Claim to send to Medicare First**
  - **Bill to Medicare as Follows**
    - **Billing NPI 1234567890**
    - **Do Not Enter Billing Taxonomy**
    - **Rendering NPI 1122334455**
    - **Rendering Taxonomy 207E00000X**

  Just enter the rendering taxonomy at the rendering provider level

Tips on Billing Crossovers

- **Scenario 2**
  - **DSHS requires only the billing taxonomy**
    - **Billing NPI 1234567890**
    - **Billing Taxonomy 332B00000X**
- **Bill to Medicare as Follows**
    - **Billing NPI 1234567890**
    - **Billing Taxonomy 332B00000X**
    - **Do Not Enter Rendering NPI**
    - **Do Not Enter Rendering Taxonomy**

  Just enter the billing taxonomy at the billing provider level

Tips on Billing Crossovers

ProviderOne

Go Electronic!

- It's faster!
- It's easy!
- No EOMB required!
- Reduce denials for duplications!

Ending the Webinar

- **To close the webinar**
  - **Click the X button in the control panel**